

preference, residential requirements, and lack of educational qualifications may actually be deterrents to the procurement of adequately trained and experienced personnel. Some method must be found whereby the procurement work of merit systems is improved, so that promotional advancements may be offered to employees, and the limitations of lack of educational requirements, total veterans' preference and residential requirements may be limited, modified, or, if necessary, removed.

7. Retirement, vacation and sickness benefits—As human beings, employees have certain rights which must be respected and certain privileges which must be offered in order to attract them to positions in public service. The provision of adequate retirement systems, vacation allowances, and sick leave are

necessary, especially in today's shortage of personnel. A specialty board for physicians in public health may be an added inducement in the procurement of adequate personnel.

8. Physical facilities—Cheerful, well furnished, well lighted and ventilated offices are a necessity to any department. Too often a health department is located either in a basement or on a top floor of a public building, in the least desirable quarters available.

9. Recognition of services—Professional and technical workers require recognition in the form of credit and praise both in professional and public circles. Ample opportunities should be provided to reward faithful and hard working health department employees in recognition of their work and accomplishments.

Financing Local Health Departments in Florida

F. M. HALL

In 1911, Dr. Hermann M. Biggs,¹ then Commissioner of Health of the City of New York, said, "Public health is purchasable. . . ." He might have added, "but not at bargain-basement prices."

Too frequently state health departments, in their overzealous ambition to see local health service established in all areas of their jurisdiction, have sold the services at bargain-basement prices to the local appropriating bodies, assuming that, once the local unit was established, it would sell itself to the community. However, if a health department is to render in the community the worth while services expected, from the beginning, the financial support must be adequate. If this adequate financial support is not available, the local health department must depend upon poorly

trained individuals to render public health services to the community. This procedure results in poor services to the people and an undesirable impression given to the local governing body as to quantity and quality of work. Thus, a health department that is inadequately financed from the beginning is unable to render the services expected, and the local governing body and the community are unfavorably impressed by such services. So, when additional funds are sought, the appropriating bodies are not interested in increasing the appropriations.

The local governing body must be given, and must assume, full responsibility for its health department, both financially and for the services to be rendered, with a minimum of supervisory or advisory control from the state and

federal levels. To secure adequately financed health services in a community there must be local autonomy, but it should be impressed upon the local officials of the community that with local autonomy goes a local responsibility—a responsibility to finance its health services adequately; and a responsibility, after such financing, that services be rendered to the community in a manner that is in accord with good public health practices.

A goodly number of local health officers today find themselves in a situation that is rather difficult to meet. The individuals responsible for the establishment of the initial budget for the area based their estimates upon a monetary situation that is entirely different from the present-day inflationary period. Emerson² and his Committee on Administrative Practices used as a guide an overall cost of \$1.00 per capita for complete coverage of six minimum full-time services.

With our ever-broadening concepts of public health, one would readily come to the conclusion, even in a non-inflationary period, that \$1.00 per capita would be inadequate in financing a program based on these six phases.

Even to carry a program embracing the basic requirements, plus a few additional programs that are needed in any area, if we consider the inflation of the day, the minimum total per capita should be at least \$2.50, with \$1.00 as local contribution. Since the services of a health department are available to the entire health jurisdiction which it serves, the local support for such a health department should come from the governing body that directs the entire health jurisdiction unless special services are requested by a municipality that is within the area. Then, of course, those special services should be financed by the municipality concerned.

When the Alachua County Health De-

partment was established in 1944, an agreement was made by the Director of Local Health Service and a local committee spearheading the formation of this health department that 53 cents per capita locally would be adequate. The area would have, after state and federal contributions, \$1.11 per capita for public health services. As inflation has progressed over the years, the governing body has always reminded the committee and the Director of Local Health Service, of their original commitments. It is felt that many health officers find themselves, through no fault of their own, bound by such commitments. Even the governing bodies themselves have been caught short by the ever-increasing cost of government.

The health officer has open to him two courses:

1. Reduce staff with a resultant curtailment of program in order that salary increases may be met.
2. Secure additional funds to maintain an adequate public health program.

The latter method is preferred. The services rendered must be maintained at the present levels because the general public, having once become accustomed to an efficient public health program, would not understand why these services were curtailed.

The method of securing additional appropriations to augment the local budget must be determined by the health officer in his own respective area. He should be, and is, better informed of the local conditions than any other individual. If the health department has rendered a service that has been adequate and efficient, the difficulties in breaking down the barrier that was once built is much easier than if, from the beginning, the services of the organization have been considered inadequate.

It is well before an attempt is made to increase the appropriations, to evaluate your own health program both as to services rendered and allocation of

time to each service. This evaluation should include the accomplishments of the department. If it can be shown from such an evaluation that progress has been made, then the health officer has in his possession one of the strongest arguments that can be presented, a

local governing body in a justification of his request for additional funds.

REFERENCES

1. Biggs, Hermann M. *Monthly Bulletin*, Department of Health, City of New York (cover), Oct., 1911.
2. Emerson, Haven. *Local Health Units for the Nation*. New York: The Commonwealth Fund, 1945, p. 2.

Fiscal Relationships Between the State and Local Health Departments in California

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The question of the fiscal relationship between the state and local health departments is squarely before us in California. This is occasioned by the passage of the Public Health Assistance law providing \$3,000,000 for local health services, which became effective September 19, 1947. This appropriation is in addition to approximately \$1,000,000 of federal funds available for local health services.

Federal funds have been allocated largely on the basis of the extent of the problem in the various areas rather than on a formula basis. Density of population, percentage increase in population, morbidity and death rates for specific diseases such as venereal disease and tuberculosis, infant and maternal mortality rates, have all been factors in the decision as to the allocation of the various federal funds available. However, these factors have not been crystallized into a definite formula. Local health departments organized during the war period were allotted relatively large amounts per capita. In a survey of the situation, allocations to local health departments were found to vary from nothing to approximately 50 cents per capita. This can be defended during periods of stress such as the recent world war, but not on a continuing basis.

The formula for the allocation of the \$3,000,000 state fund for local health services is written into the law. Each county receives a basic allotment of \$16,000 or 60 cents per capita, whichever is less. The remainder, after subtraction of $7\frac{1}{2}$ per cent of the total for administrative and consultative services and training, is allocated to health departments meeting standards on a straight per capita basis.

In effect, counties with a population of 26,000 or less, and meeting minimum standards, receive approximately 82 cents per capita regardless of whether they operate individually or as a part of multi-county health units. Larger health jurisdictions receive a gradually decreasing per capita allotment, so that the metropolitan areas receive between 22 cents and 23 cents.

With this fairly liberal allocation of state funds, especially to the smaller health jurisdictions, we ask ourselves the question, "Should not a large proportion of the federal funds available for local health services also be allocated on a formula basis?" This administrative question has not been answered.

Our Public Health Assistance Act officially sets up a California Conference of Local Health Officers. This Con-